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THREE DIAGNOSTIC SIGNS OF MELANCHOLIA.¹

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TRUE melancholia may be divided into simple melancholia, melancholia agitata, melancholia attonita, and melancholia with stupor. It is mainly of the first of these forms, of the slighter cases of the second form and of some few cases of the fourth type that I propose to speak. In the simple form of melancholia, as we all very well know, there is a melancholy, which is usually unattended by delusions, hallucinations or illusions, although there may occasionally be delusional or hallucinatory tendencies, but there is none of the agitation or stupor of the other forms. The simple forms of melancholia are often extremely difficult to diagnosticate, especially in the early stage, as the reasoning powers, the memory, and the perceptions are then often seemingly unimpaired, or not more affected than is possible from a myriad unimportant causes. Patients suffering from this mental disease too frequently figure as neurasthenics, to be confidently treated as such until some determined and frightful suicidal or homicido-suicidal attempt throws startling light upon the true nature of the malady. These, too, are the cases of unaccountable

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suicides which puzzled friends and competing newspaper reporters account for so satisfactorily and sensationally upon some theory of rejected love or high-flown sentimentalism. Any certain diagnostic symptoms in this class of cases should be for these reasons of value. In sixteen cases of melancholia of the above types which I have had under observation in the last eighteen months, I have found three constant symptoms, viz., the melancholia, marked insomnia, and a post-cervical ache.

The melancholy is different from simple sadness. In the latter there is some cause for the mental depression which the patient recognizes and seeks to have removed, and the mental faculties are not at all affected. In melancholia, on the contrary, there is seldom any adequate cause for the depression which the patient will often not recognize the presence of, and about the treatment of which he or she is often utterly indifferent, if indeed, he or she be not obstinately opposed to any treatment; and a careful examination will show a certain dullness of mental reflex, made perceptible by slower responsive acts or words than is usual to a healthy mind. In the more marked cases of simple melancholia, especially in those bordering upon the agitated and stupid types, careful and close questioning will elicit from the patient a history of delusion and hallucinations—rarely illusions, if I may judge by my own experience—of a melancholy and more or less terrifying nature. The characteristics of this peculiar melancholy—the causelessness, the indifference, the slow mental reflexes, with the occasional history of terrifying delusions and hallucinations—are remarkably constant, and they are so significant that I have again and again based upon them a diagnosis which further examination has verified.

The post-cervical ache is, as I have indicated by the name which I have ventured to give it, an aching pain in the back of the neck, head, and sometimes into the shoulders. It is usually described as a distress or ache, although it may occasionally be neuralgic in its character, and not infrequently passes into neuralgic paroxysms which will last for a day or two.

The insomnia is usually one of the earliest symptoms of the disease, but has no especial characteristics of which I am aware.

The following histories will demonstrate that these three conjoined symptoms of melancholia, insomnia and post-cervical ache were constant.

CASE I.—Miss —, age thirty-five, had a severe attack of melancholia three years ago, caused by the sudden death, by a fall from his horse a few days before the intended marriage, of the gentleman to whom she was betrothed. The melancholia lasted for upwards of a year, and it was not until about a year ago that she came under my care. She then complained greatly of obstinate insomnia, and severe aching in the back of the head and neck. For a year this patient has been under my treatment, so that I have been able to observe in her the existence of a fixed melancholy, of such a nature that it seems utterly impossible for her to receive a pleasant impression of any kind. At times she has attacks of dull aching pain in the back part of the head, neck and shoulders, and at the same time she becomes more or less sleepless. These attacks have usually been mild in character, and have yielded after about a week of treatment, but occasionally they have become very severe, and the post-cervical ache has become actual pain of considerable intensity, the insomnia has become pronounced, and the melancholiac condition had deepened and has been attended with mental confusion and hallucinations.

CASE II.—Mrs. B., widow, had attack of melancholia *agitata* about eight years ago, during which she made repeated and determined attempts at suicide. When I saw her a year or two after the acute symptoms had disappeared she had a fixed melancholy which no reasoning could influence; slept only three or four hours each night, and was troubled with a constant aching, uneasy feeling in the back of the neck and head and in the shoulders. During the years that have since elapsed, in which this patient has either been under my care or so situated that I have known accurately of her condition, she has had almost uninterruptedly the fixed melancholy, the poor sleep and the post-cervical aching. At times the insomnia has become very obstinate, and the post-cervical ache has mounted into severe neuralgic distress, but she has had no increase of her mental symptoms.

CASE III.—Mrs. M., sent to me September, 1888, by a physician. She gave a history of a meningitis following insulation many years ago. During the last six months she has been suffering from melancholia, obstinate insomnia, slight hallucinations, and constant distressing aching in the back of the head and neck and in the shoulders. Under treatment these symptoms disappeared, with the exception of some slight aching in the locality described, and the patient was doing very well when she was again sunstruck in the early part of the summer, and had another attack of meningitis, since when I have lost sight of her.

CASE IV.—Miss —, brought to me by a physician, had had melancholia for some two months, and had made two determined attempts at suicide. She had a causeless melancholy which could not be reasoned away, but had never had any hallucinations or mental confusion, had obstinate insomnia, and well-marked aching in the back of the head and neck and in the shoulders. This patient has improved very greatly during the year that has since elapsed, I am told, but she still suffers from her melancholy, occasional insomnia, but I have not been able to inform myself in regard to the post-cervical aching, as I have never seen her but upon the one occasion of the consultation with her attending physician.

CASE V.—Miss —, age forty, seen in consultation in a neighboring city. She has a causeless melancholy, slight hallucinatory tendencies, has talked longingly of suicide, but has made no attempt at it; has suffered from obstinate insomnia, and has considerable distress in the back of the head. This patient refused to be treated, and I know nothing further accurately of her history.

CASE VI.—Miss —, age thirty-two, seen in consultation. She had had slight melancholy, entirely causeless; had spoken about suicide, but never made any attempt at it; suffered from insomnia for about two weeks, and also from distress in the back of the head and neck. This case had made an excellent recovery in some six weeks under treatment of the attending physician, and when I saw her in consultation she was only suffering from the distress in the back of the head and from slight melancholy. This was altogether one of the mildest cases that I have ever seen in my life.

CASE VII.—Miss —, age twenty-five. This patient had a severe attack of melancholia, with considerable agitation, obstinate insomnia, marked suicidal tendencies, but manifested no symptoms of the post-cervical aching. I attended her for some eight weeks, during which her condition did not materially improve, except that the insomnia was successfully combatted with hypnotics. She then passed out of my charge; whether she afterwards had a post-cervical ache or not, I am unable to say, or as to what her further symptoms were.

CASE VIII.—Miss —, age twenty. This was a case of mild melancholia agitata, with marked melancholia and melancholy hallucinations and some slight mental confusion. This patient committed suicide in a most determined and seemingly intelligent manner by taking the poison known as "Rough on Rats."

CASE IX.—Mr. —, age sixty-seven. This patient is suffering at the present time from melancholia, with marked suicidal and homicidal tendencies, slight hallucinations and great insomnia, but has no post-cervical ache.

CASE X.—Mr. —, age thirty-seven. Came to my office complaining of pain in the back of the head and neck. Something in the man's manner aroused my suspicions, and I found that he had, about six years ago, whilst living in Further India, an attack of melancholia with obstinate insomnia, slight mental confusion for a short time, and suicidal tendencies, all these symptoms having lasted about six months, and since this time he has had an aching post-cervically, which often passes away and leaves only a neuralgia over the left ear and scalp. This patient is still under treatment.

CASE XI.—Mr. —, age thirty-four, is very melancholy and apprehensive, has obstinate insomnia, sleeping about four hours with large doses of sulphonal, and has a constant drawing pain in the neck and shoulders. No suicidal tendencies. This patient is still under treatment.

CASE XII.—Miss —, age twenty-eight. Seen in consultation in a neighboring city. For about a year has had constant and great insomnia, pronounced melancholy, occasionally becoming greatly agitated and so marked that the patient would shut herself up in her room and cry

incessantly. Has constant pain in the occiput, which is at times quite severe. Has slight delusions.

CASE XIII.—Miss —, age thirty. Great melancholy for the last six months and obstinate insomnia for the same time. Has a weary aching feeling over the back and the top of the head. During the last ten years she has had several similar attacks, lasting two to three months, with insomnia, aching post-cervically and at the vertex. In one of these attacks she had a hallucination of sight, otherwise no hallucinations or delusions in any of these attacks. Has had suicidal ideas frequently suggest themselves to her, but has been able to repel them.

CASE XIV.—Mrs. —, age forty-two, wife of a physician, came to me complaining of great aching distress in the back of the head and shoulders. This led me to interrogate her closely, when I found that she had just recovered from an attack of typical melancholia with obstinate insomnia, marked suicidal and homicidal tendencies, which nothing but her strong religious feelings had enabled her to control, and which she had suffered for some six months without daring to tell her husband. This patient is still under treatment, and is almost recovered from the aching and the occasional attack of melancholy which were all that have been left of her former attack.

CASE XV.—Mrs. —, age thirty-three, sent to me by a physician. About nine months ago was attacked with melancholia shortly after severe domestic misfortune, suffered for three consecutive nights absolute sleeplessness and then began to suffer from pain in the back of the head and down the spine. Since the onset the melancholy and the ache have been present almost the whole time, but the insomnia has been treated with fair success, although she still sleeps badly and is a long time in getting to sleep. At first she had optic hallucinations occasionally.

CASE XVI.—Miss —, age twenty-six. About one year ago, after great worriment and night work in nursing her mother, she began to be very sleepless, and to have an aching feeling in the back of the neck and become very melancholy. In the last three months she has heard a constant crackling sound at the back of the head. Has never had the slightest suicidal feeling.

In cases of melancholia with stupor and the melancholia attonita, I have not been able to ascertain whether or not the post-cervical ache was felt, possibly because of the stupor, but I do not think that these cases complain of it after recovery. In the cases of simple melancholia and the milder cases of agitated melancholia, the post-cervical ache is apt to last for many years in certain patients after the main disease has been entirely removed, and in some of this class it will occasionally merge into violent neuralgic attacks, during which the insomnia will return, and there may supervene some slight mental confusion and melancholia, although these recurrent attacks seldom last over a week, and are very easily treated. The insomnia is apt to be an obstinate symptom for a certain length of time in all the forms, but the cases of melancholia attonita and stupid melancholia do not suffer from insomnia after they have recovered from the main disease as much as do the cases of simple melancholia and the slighter cases of the agitated form. In the latter two classes it is not unusual to find patients suffering constantly from slight insomnia for many years, and at times becoming so sleepless as to necessitate large doses of hypnotics.

So firmly have I come to rely upon the association of this symptomatic triad that I have lately made a diagnosis in two cases by means of it. The first patient was a gentleman who came to me complaining of a distress in the back of the head and neck, which at times was painful. I learned from him that the onset dated back to six years ago, when, as he said, he had been run down and depressed. I then told him that I would outline to him his symptoms at that time, and I proceeded to tell him that he had been very very much depressed, had not been able to sleep, had thought of committing suicide, had been slightly confused in mind, and had remained in this condition for several months. He was amazed, and asked me if I was a mind reader, finally admitting that he had passed through just such an attack of melancholia, which he had concealed from everybody because he was then living in Burmah in the employ of the English Government, and was afraid that

he would lose his position if they should think him insane. The other patient was a lady who came to me complaining of the same vague distress in the back of her head and neck. I also ascertained from her that the trouble dated back some six months; and I then asked her whether she had not at the beginning been very much depressed. She answered me in the affirmative with so embarrassed an air as to make me assured that there was something concealed, and I then went on to recapitulate to her the symptoms of melancholia as I had done to the man from Burmah. She burst into tears, and admitted that she also had passed through an attack of melancholia, and astonished me in her turn by telling me that she was the wife of a well-known physician, and that she had concealed all knowledge of her mental condition from her husband, because she was afraid that he would send her to an asylum. This poor woman had absolutely on several occasions felt so strong an impulse to kill her children and herself that she had been obliged to leave the house and get away from them.

It seems to me that the knowledge of this conjunction of symptoms should be of value for both diagnostic and therapeutic reasons. Every physician in general practice, and still more every neurologist, knows how difficult it is at times to feel sure as to whether a given case of depression is one of hysteria, of grief, of depression from a gastrointestinal disorder, of depression preceding the outbreak of some other form of mental disease, or whether it is true melancholia. In the latter the suicidal and homicido-suicidal tendencies are so organic a part of the disease that the mildest case is not to be trusted, and valuable lives may be saved by some method of prompt recognition. I have no hesitation in saying that the most ghastly crimes in the annals of lunacy are those which are committed by melancholiacs who are suffering from simple melancholy, without stupor and either without delusion or hallucination or with slight tendencies of the two latter kinds, for these patients seem so reasonable and intelligent that no check is put upon them, and they attain their diabolical ends with a directness and success that is not possible to any other

class of the insane. I have known of one patient secreting for months a match under her thumb nail and a wisp of light paper in her axilla, finally to draw out the paper and light it with the end of the match and deliberately set fire to her gown so as to burn herself to death. I have known another patient, who had been watched for weeks, but who had seemed perfectly quiet and inoffensive, yet slink out of the house at midday, walk two miles to the Park, deliberately search for the most secluded part in it, remove his shirt and tear it into strips, make a rope of the pieces, and hang himself to the bough of a tree. And I could go on multiplying instances, which all of you could probably match, of women who have killed their children, of husbands who have killed their wives, of lovers who have killed the beloved, until the recital of horrors would equal the bloody reign of the Duke of Alva and the Inquisition in the Netherlands. From a therapeutic point of view the recognition of the insomnia and the post-cervical ache should enable a physician to diminish the distress and the consequent aggravation of mental symptoms.

I venture to hope that the medical profession will observe this triad of symptoms, so that we may ascertain the percentage of its presence in a greater number of cases than it has fallen to my fortune to observe.

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